Physician Profile Service Order Form for Licensure Application or Renewal

THIS FORM IS FOR PHYSICIAN USE ONLY

To order, please complete this form and submit to the American Medical Association. Profiiles are sent directly to the specified Licensing Board within 3 weeks. You may order your Profile on-line at www.ama-assn.org. Click on Products, Services; Credentialing Products and Ordering. Please call us with your questions at (213) 464-5199, 8:30am-4:45pm CST.

American Medical Association
Department of Data Services
515 N. State Street
Chicago, IL 69610

___I AM A MEMBER

As an AMA memeber benefit, there is no charge for your physician profile request. Please submit completed form and return it by mail to the address above, or fax to (312) 464-5827.

___I AM NOT A MEMBER

Please submit this form fully completed with a check for $16/profile ($25/profile for Express 30 day service) made payable to the American Medical Association. Send to AMA, Remittance Control Area/PPS, Accounting Department, PO BOX 109054, Chicago, IL 60610, or include your credit card number below. Fax orders (credit card payments only) to (312) 464-5900.

___Visa

___American Express

___MasterCard

Amount of Payment: $ _____

Credit Card Number _____ Expiration _____

Signature _____

Join or renew your membership in the AMA today - call 800-AMA-3211

PART 1: STATE LICENSING BOARD INFORMATION

Please send my profile to the following State Licensing Board(s):

Licensing Board Type: ___ MD? _____

___ DO? _____

PART 2: PHYSICIAN INFORMATION

PHYSICIAN NAME

Suffix _____

First Name _____ Last Name _____ M.I. _____

SSN _____ Date of Birth _____

Place of Birth _____ E-mail Address _____

Medical Education #_____

HOME ADDRESS

*Street 1 _____

Street 2 _____

*City _____ *State _____

*Zip Code _____

*Home Phone _____ Home Fax _____

PRIMARY OFFICE ADDRESS

*Street 1 _____

Street 2 _____

*City _____ *State _____

*Zip Code _____

*Business Phone _____ Fax _____

PREFERRED MAILING ADDRESS

Home Business

PART 3: MEDICAL EDUCATION AND OTHER INFORMATION

Medical School of Graduation _____ Year of Graduation _____

DEA# _____ ECFMG# _____

RESIDENCY TRAINING

Institution	Hospital Name	Location	Years
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HOSPITAL ADMITTING PRIVELEGES

Hospital Name	City	State

GROUP PRACTICE AFFLIATION(s)

Hospital Name	City	State

PHYSICIAN AGREEMENT

Agreement must be signed in order to process your request
AMA endeavors to maintain its physicians' records with information that is complete, current, and timely; however, because of possible reporting and processing delays, no representations or warranties as to the accuracy or completeness can be or is made. In consideration of the receipt of your physician record provided by AMA, hereby release AMA, its agents and servants from any and all liability whatsoever for inaccurate or incomplete information in such physician record. Submission of this form and payment of feee (if applicable) shall be conclusive evidence of your understanding and agreement to the above stated terms and conditions.

Signature _____ Date _____